Accepted 5/4/09 mf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS1955AGC	A. BUILDING _____ B. WING _____	04/22/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY RESIDENTIAL CARE	3060 LIBERTY CIRCLE S LAS VEGAS, NV 89121

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on April 21, 2009. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness and/or persons with chronic illnesses. The census at the time of the survey was nine. Nine resident files were reviewed and three employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of A. The following deficiencies were identified:	Y 000	RECEIVED MAY 04 2009 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA	
Y 103 SS=F	449.200(1)(d) Personnel File - NAC 441A NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee. This RULE: is not met as evidenced by:	Y 103	Y103 a) Employee #1 has done the 1st TB skin test on 4/23/09 and the 2nd on 4/30/09. Employee #2 has already done her skin test on 2/20/09. (Attachment 1 & 2)	OK mf

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Katrina A. Angst — TITLE: Administrator — (X6) DATE: 5/1/09

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Y 103	Continued From Page 1 Based on record review on 4/22/09, the facility failed to ensure 2 of 3 caregivers complied with NAC 441A.375 regarding tuberculosis testing (Employee #1 and #2) for the protection of all residents. This was a repeat deficiency from the 5/7/08 State Licensure survey. Severity: 2 Scope: 3	Y 103	continued . . b)All prospective employee will going to have two-step TB skin test prior to hiring and an annual skin test will be done within 365 days. The administrator will monitor compliance. c) 4/30/2009.	OK mpf 5/4/09
Y 178 SS=D	449.209(5) Health and Sanitation-Maintain Int/Ext NAC 449.209 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. This RULE: is not met as evidenced by: Based on observation and interview on 4/22/09, the facility failed to ensure the premises were kept clean and well maintained (In Bathroom #1, the integrity of the wall has been compromised by water causing tiles to fall off). Severity: 2 Scope: 1	Y 178	Y178 a)The tiles in the bathroom #1 has been fixed and there is no water in the retaining wall.(Attachment# 3&4). b) The facility has a maintenance person to do the repair to ensure that the premises are well maintained. The administrator will monitor compliance. c) 4/29/2009.	OK mpf 5/4/09